ACADEMIC CHILD PSYCHIATRY: A PERSONAL VIEW*

CLARICE J. KESTENBAUM, M.D.
Columbia University College of Physicians and Surgeons
New York, New York

TODAY I would like to share with you how I became an academic child psychiatrist. My personal journey through the psychiatric world may help bring into focus for some of you a career choice that for me has been exciting and rewarding.

I address you today from the viewpoint of a training director. Two years ago I would have spoken as an administrative psychiatrist, the Director of the Division of Child and Adolescent Psychiatry at the St. Luke's site of the St. Luke's-Roosevelt Hospital Center, a post I held for 15 years. Prior to that I would have come before you as the Director of the Child Psychiatry Consultation-Liaison Service at St. Luke's and even earlier as a consultant to the Hudson Guild Therapeutic Nursery. Throughout the twenty years since my graduation from Columbia's general and child psychiatric training program, I could have spoken to you as a community psychiatrist involved in the children's service subcommittee of the Morningside Catchment Area's planning group as a clinician—a child psychiatrist and psychoanalyst, and a clinical investigator in the area of children at risk for psychotic disorders in adult life.

Most academic psychiatrists of my generation have a similar background. The varied experiences have certainly helped to develop a holistic approach, eclecticism and a broad-based view of child psychiatry. I believe that this approach has been more beneficial than any other ingredient in helping me to become an effective teacher. At the present time I am director of training in the division of child psychiatry, Columbia University College of Physicians and Surgeons. The route I took to arrive at this point was circuitous indeed.

*Presented as part of a *Symposium on Career Opportunities in Child and Adolescent Psychiatry* held by the Section on Psychiatry of the New York Academy of Medicine with the New York Council on Child Psychiatry and the Society for Adolescent Psychiatry at the Academy February 6, 1986.

This work was supported in part by NIMH Grants MH-32212 and MH-40177, by a grant from Stallone Fund for Autism Research, and aided by Social and Behavioral Sciences Research Grant No. 12-108 from March of Dimes Birth Defects Foundation.

In similar fashion the field of child psychiatry has developed from many diverse paths and directions. The field is actually very new. Certification in child psychiatry only began in 1959. The first child analytic case report familiar to all of you (Little Hans) is only 80 years old, and adolescent psychiatry has been a separate entity for about half a century.

The parentage of child psychiatry itself can be divided into not two, but five component parts: the mental hygiene movement and the juvenile court system which led to the child mental health clinics and agencies; education and the teachings of John Dewey, nursery school and kindergarten experience; behavioral psychology with the introduction of standardized tests and measurements for cognitive development; pediatrics with its emphasis on physical developmental norms; and finally psychoanalysis, the emphasis on childhood neurosis and the examination of children as a way of studying psychopathology *in statu nascendi*.

Many of the early pediatrician-psychiatrists like Benjamin Spock and David Levy set the tone of clinical practice and clinical research for decades to come. I remember David Levy's approach to psychiatric measurement in the days before questionnaires and structured interviews even existed. His personal scale to determine whether a mother was showing an appropriate response to her infant at the initial well-baby visit was to say to the mother who was holding her child, "Oh Mrs. Smith, what a lovely little girl you have there." If the mother looked at her baby and smiled while he offered the compliment he knew that bonding attachment would occur; if she didn't look down or looked depressed or upset, he knew that something was wrong. He would make a little note on the chart that the mother may need mental health services by the next visit.

My own professor of child psychiatry, William Langford, was similarly trained as a pediatrician and general psychiatrist. Our training was relatively informal, and those of us who decided to follow his footsteps had nonetheless to "play it by ear."

There were no formal standards for residency training—each program specialized in whatever the professor knew best. Trainees at Bellevue had the good fortune to learn about childhood schizophrenia on site from Loretta Bender and Barbara Fish. I probably learned more about the Riley-Day-Langford Syndrome (dysautonomia or crying without tears) than anyone else in town, since it originated with us. Training was catch-as-catch can. The two or three child psychiatry fellows had dozens of fascinating cases to discuss with a half-dozen supervisors and attending physicians. We had the lux-

ury of keeping a case as long as we wanted; there were no Medicaid forms or DRGs to contend with; our notes read like novels—full of speculation, fantasy, hyperbole and sometimes a thoughtful analytic discussion of all the factors that led to Johnny's inability to control his cursing or inordinant fear of dogs. Many of us met in small groups in the evening to read and review important child psychiatric papers; we taught ourselves and we taught each other; we learned how one case could be treated in a variety of ways; pharmacologically, behaviorally, psychoanalytically—depending on the favorite paradigm of a particular supervisor. We developed the ability to work in teams as well as "do it all yourself," including initial psychological testing, social service intake, and home visits. The situation is altogether different today since the formation of the Residency Review Committee for Child Psychiatry. Training is far more standardized, and specific requirements are mandated for each accredited training program.

At the same time, 20 years ago, while child fellows were learning how to treat children with emotional problems by the trial and error method, we were beginning to demonstrate our expertise to those even less experienced than we were. It was the era of paraphrasing the surgical intern's motto "see one, do one, teach one." The child psychiatry fellows were called upon to teach the general residents, medical students, pediatricians, and to consult with schools and agencies after a few months of training. The day I was graduated I accepted a job at the Hudson Guild as consultant to the therapeutic nursery, a position formerly held by none other than Margaret Mahler. That was an impossible act to follow, but I read everything I could about symbiotic psychosis and separation disorders and soon developed my own consultation style. I was supposed to conduct a weekly child development didactic seminar as well as to discuss any clinical problem that a teacher presented. Parent groups met from time to time as well. After a year I became reasonably comfortable with lecturing to small groups.

Having a very small private practice, I took a job as director of consultation liaison at St. Luke's. In those days most hospitals would not permit parents to stay overnight with preschool children or to remain with them during the better part of the day. Bowlby's work on the sequelae of in-hospital separation from parents was not yet accepted by the pediatric community in the United States. There were no child-life programs that prepared children for tonsillectomies and herniorrhaphies; many of us did presurgerical play therapy with the pediatric patients. We lectured to general practitioners on the emotional care of hospitalized children and to mental health workers

in local agencies on "the best time to refer to a child psychiatrist," or "how long do you wait for a child to outgrow it?"

During these early postgraduate years I did a fair amount of medical student teaching. A group of general residents made a film interviewing hospitalized children. The natural style of the students coupled with the open responsiveness of the young patients served to make the film a unique method to teach residents the adaptive and maladaptive coping mechanisms of children in stressful situations. The video tape was the first in a series of a dozen or so child development tapes made at the New York State Psychiatric Institute. These tapes on early and middle childhood, adolescence, parenting, and assessment became superior training tools, available upon request to those of us who were teaching to various groups.

The teaching tapes led me to develop a childhood assessment instrument together with my colleague, Hector Bird, for use in the New York High Risk Schizophrenia Project. Over the next decade the interviews were developed and conducted by dozens of St. Luke's child psychiatry fellows specially trained in administering them.

Throughout the clinical research, lecturing, teaching, and production of videotapes I continued to see many patients in psychotherapy and psychoanalysis, the basis for furthering understanding of psychopathology as well as normal development. Thus I became an academic psychiatrist. Today the world of a child psychiatry fellow is very different. Training is more structured. During a two year child psychiatry fellowship most trainees receive practical experience in evaluating and treating emotionally ill children and their families in a variety of settings—inner city community clinics, inpatient child and adolescent units, pediatric wards, normal and therapeutic nurseries. They learn about the juvenile and family court system, school consultation, infant psychiatry, and subspecialties such as psychoendocrinology, neuropsychiatry, and child abuse. They receive a solid basis in individual dynamic psychotherapy, group and family therapy, behavior therapy, psychopharmacology; for many fellows there is the opportunity to lecture and teach even though they may not want to pursue a full-time academic career but wish to continue as a voluntary member of a child psychiatry division. Many programs have a third fellowship year in a subspecialty of child psychiatry, basic research, clinical research or career development. A child fellow involved in such a training experience is expected to participate in the teaching program. In many cases he attaches himself to a senior staff member as a kind of apprentice, and learns whatever the mentor can teach him.

I have not mentioned the premedical training many junior academic psychiatrists have had. Many had studied philosophy, psychology, literature, not only the physical sciences, which served to broaden their vistas in an academic setting. I have encouraged those interested in pursuing an academic career to complete psychoanalytic training or at least have psychoanalytically oriented therapy, to attend psychiatric conferences, and present papers on aspects of their work, as well as keep an active psychiatric practice (no matter how small) divided between consultation and therapy.

The road to academia is much smoother for budding child psychiatrists now than it was 20 years ago. The field is surging forward by leaps and bounds. There is a great need for well educated broad-based child psychiatrists to swell the professional ranks in our universities and medical schools.

I encourage all of you who have an interest in pursuing a fascinating, worthwhile career to consider a fellowship in child psychiatry. I am sure you will find this subspecialty as rewarding as I have.